Developing urgent care and rehabilitation

Welcome and Introductions

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Developing local hospitals

Aims of today's workshop:

- Provide an opportunity to share our learning from the ongoing engagement process
- Explore with you what this could mean for potential options we need to develop
- Get your thoughts and feedback on these possible options and the impact of travel and access for patients, families and carers
- Get your thoughts and feedback on what further information is required for consultation

What you told us – feedback from the Roadshows

- The need for a locally based A&E service in Banbury to support the growing population.
- Concerns over sufficient ambulance provision in Banbury if A&E services were to be based only in Oxford.
- The increased difficulty in travelling to Oxford for frail and elderly people or those in more remote villages – again underlining the need for more local care.
- An ageing population requiring a higher level of use of health and care services was understood by the public to be one of the main reasons for change.
- Integration across health and social care was seen as something that is essential to help ensure all other factors are successful. This was particularly highlighted for elderly care.
- The value of appropriate services for the elderly to ensure more people are kept healthy. This includes the role that some non-health/social groups and voluntary groups play in preventing loneliness and supporting those with dementia.
- The need to recruit more GPs and increase GP provision locally to help prevent high use of A&E services.
  To co-locate some GPs in A&E to manage inappropriate attendances.
- Concerns about what will happen to patient beds/patient care if community hospitals close.
- Prevention/education sessions in the community on maintaining a healthy lifestyle for the elderly.

Next steps

- A detailed report on feedback received to date called the **The 'Big Health and Care Conversation' Engagement Report** has been produced.

- The report will be made available to the public online at https://consult.oxfordshireccg.nhs.uk/consult.ti/Bighealthandcare/consultationHome

- Feedback will be used to help further develop the models of care and future service options which will be subject to a public consultation later in the year.

- On-going engagement including briefing and feedback sessions with stakeholders and including engagement with seldom heard people and groups in the county.

Our vision

- The best quality care provided to patients as close to their homes as possible
- Health professionals, working with patients and carers, with access to diagnostic tests and expert advice quickly so that the right decision about treatment and care is made
- Ensuring, as modern healthcare develops, our local hospitals keep pace, providing high quality services to meet the changing needs of our patients
- Preventing people being unnecessarily admitted to acute hospital or using A&E services because we can't offer a better or more local alternative
- Best bed is your own bed

Do we use inpatient beds appropriately?

- Evidence suggests that many patients are admitted to hospitals who do not need to be and many remain within the hospital environment for much longer than they need to be
- Snapshot audits of NHS acute and community hospitals provide compelling evidence. They focus on:
  - Whether the patient should have been admitted in the first case
  - Whether those patients who were correctly admitted originally still needed to be in hospital

Assumptions:

- The necessary services are in place to provide the “right” level of care, and
- The necessary capacities are in place to provide the “right” level of care

Do we use inpatient beds appropriately?

- Average of findings from similar surveys across the UK suggest:

	% of admissions of patients that did not need this level of care	% of patients who needed to be admitted, but could now be at a different level of care	Total % of patients who could be supported at a lower level of care
Reviews of relevant acute hospital wards	23%	56%	44%
Reviews of community wards	20%	52%	41%

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Do we use inpatient beds appropriately?

What does this suggest?

- Of those currently in **acute services** who do not need to be at that level of care
  - 47% could be supported in their own homes
  - 32% would require some form of bedded provision, either in a community hospital or some form of intermediate care.
  - 12% would require supported living accommodation
- Of those currently in **community hospital** beds who do not need to be at that level of care
  - 48% could be supported in their own homes
  - 45% would require some form of inpatient/supported living accommodation.

Timeline July - October

Calculate the number of beds needed

- Based on current & predicted demand
- Whether this should include ‘Step up and step down’
- Audit of current community hospital inpatients

Establish whether direct admission model is viable

- Medical, nursing and therapy workforce needed (current and future)
- Clinical & diagnostic infrastructure

Review of Direct Admission Model (Step up)

24/7/365 access is required. Our assumptions are that;

- “front door assessment” require 11.5 wte medical provision for each site
- Each ward would require 10 wte medical provision

- We need to rethink our options. We cannot rely upon models where acute doctors are providing time in distributed locations
- More dependent upon community staff, GPs and enhanced primary care models

Community Hospital 'Step-down Beds'

Increased acuity and frailty of these patients means;

- A high ratio of nursing and therapy staff with significant networked medical staffing are required. (challenging to deliver in smaller settings)
- Develop clinical skills of 'non medical staff' (nurse consultant and advanced therapists)
- Diagnostic support using technology/OUH clinical liaison hub

What are the typical patient needs

- Post-trauma rehabilitation (i.e. hip fracture)
- Reablement/rehabilitation following medical crisis
- Slower stream recovery for patients with specific needs – advanced dementia/very limited mobility complex discharge arrangements required

What do we currently think this means ?

- Local hospitals delivering ‘Step up beds’ model is not likely to be deliverable
- Improve access to MDT assessment through
  - local Urgent Care Centres without inpatient beds
  - Use of ‘Frailty assessment units’ to undertake more comprehensive assessment and intensive treatment when required
- Step down beds concentrated in fewer places
- Needs to fit with options for the Horton to give consistent patient access across the county

What do we currently think this means in the community ?

- Patients may still need to be cared for in a bed though this may be a less traditional bed
  - Extended intermediate care with in-reach medical nursing and therapy support
- More than 2000 patients could be supported in their own homes rather than hospitals. The outcomes for these patients is better and what patients tell us they want
- Improve access to MDT assessment and treatment in locality settings working with primary care

Criteria You Identified as important!

- Travel times (not distance)
- Population growth predicted
  - Demographic breakdown
- Patient outcomes
- Domiciliary support

Questions that we would like you to consider?

- What do you think the issues might be in delivering rehabilitation of high quality though in fewer places?

- If we are delivering more care at home, what would the the characteristics of a good home care package be?

Options – Key Messages

Whole system reform across Acute, Community, Primary Care

Clinical sustainability and affordability

Trade-offs and choices between physical access, quality and money and investment in capacity of community based care closer to home services

Emerging Whole system options

Tier and type of beds	Locality/site options
Very specialist (Tertiary) beds e.g. cancer, neuro, cardiac etc	JR/Churchill/NOC (as now, no plans to change being proposed)
General acute for medicine and surgery	Centralised at Oxford - JR/Churchill/ NOC OR Split across Oxford and Horton DGH
Step up & step down (EMU+) and complex rehabilitation Intermediate/nursing home	Up to 4 sites with NHS beds across Oxfordshire Located in Oxford, Horton, South, West Plus Nursing homes and Care homes
Own bed	Everywhere (across Oxfordshire)
Maternity	Obstetric (consultant deliveries) All at JR or split across JR and Horton DGH Plus midwife led units
Long Term Conditions, Frail Elderly, Assessment & Diagnostics	Accessible to all localities integrated with primary care

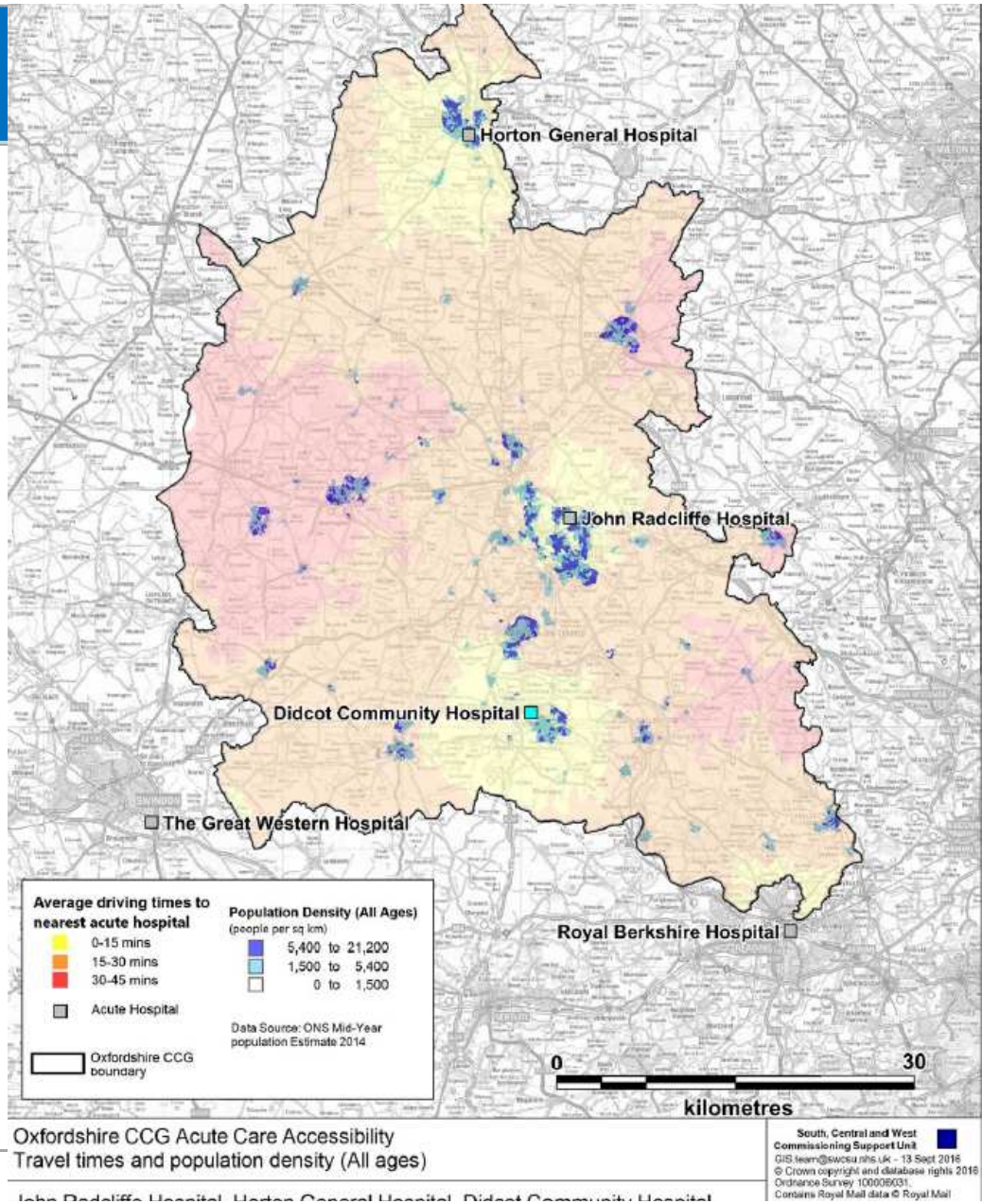
Any Questions??

Original proposals

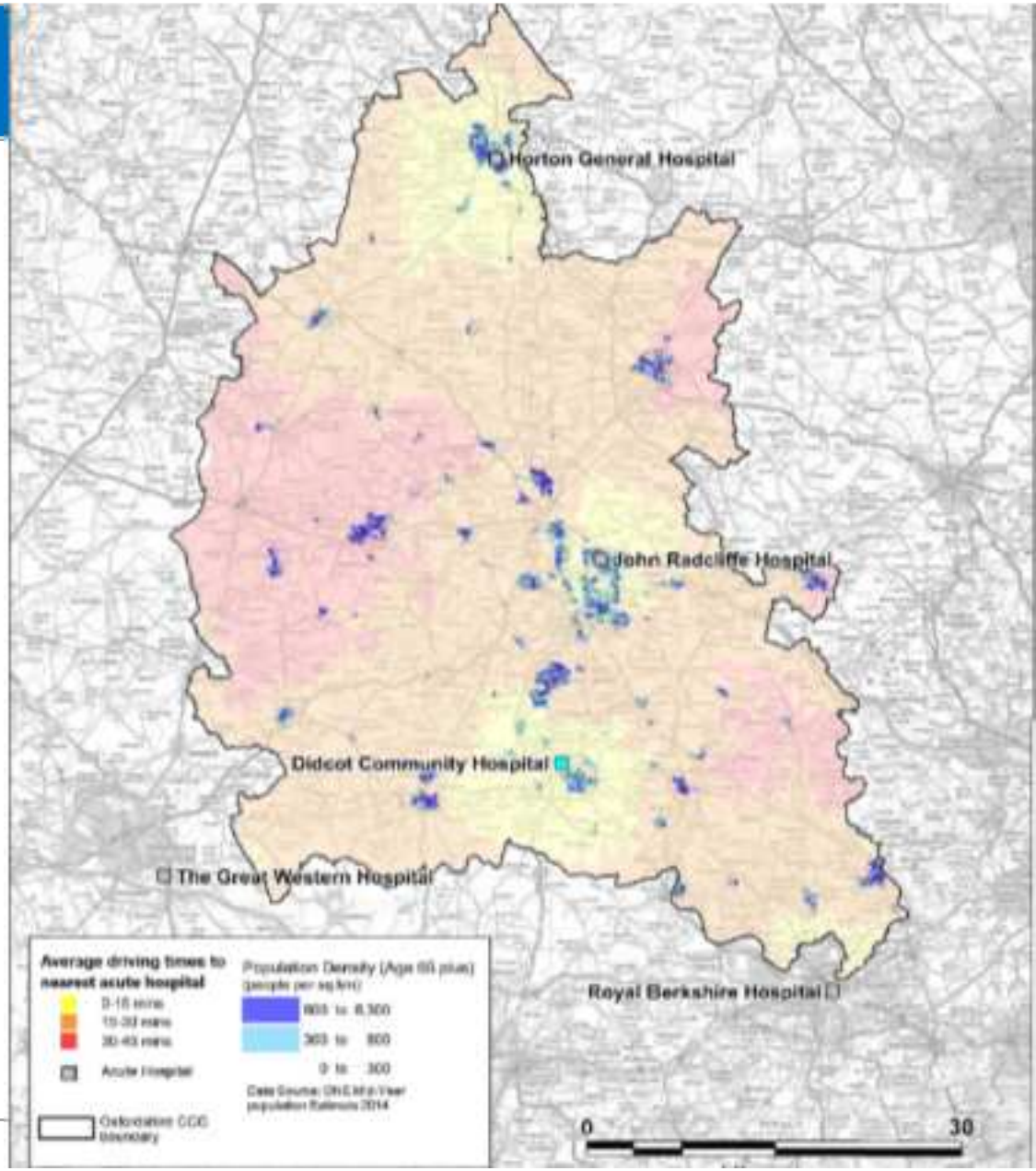
- **Stay as we are** (patients are admitted first to acute – then some are transferred to a community hospital)
- Have only **one site** for whole county
- Have **two sites** *(Horton, Oxford)*
- Have **three sites** *(Horton, Oxford, South on A34 corridor)*
- Have **four sites** *(Horton, Oxford, South on A34 corridor, Witney)*
- Have **six sites** (one for each GP locality)

We can only consult on options that are feasible

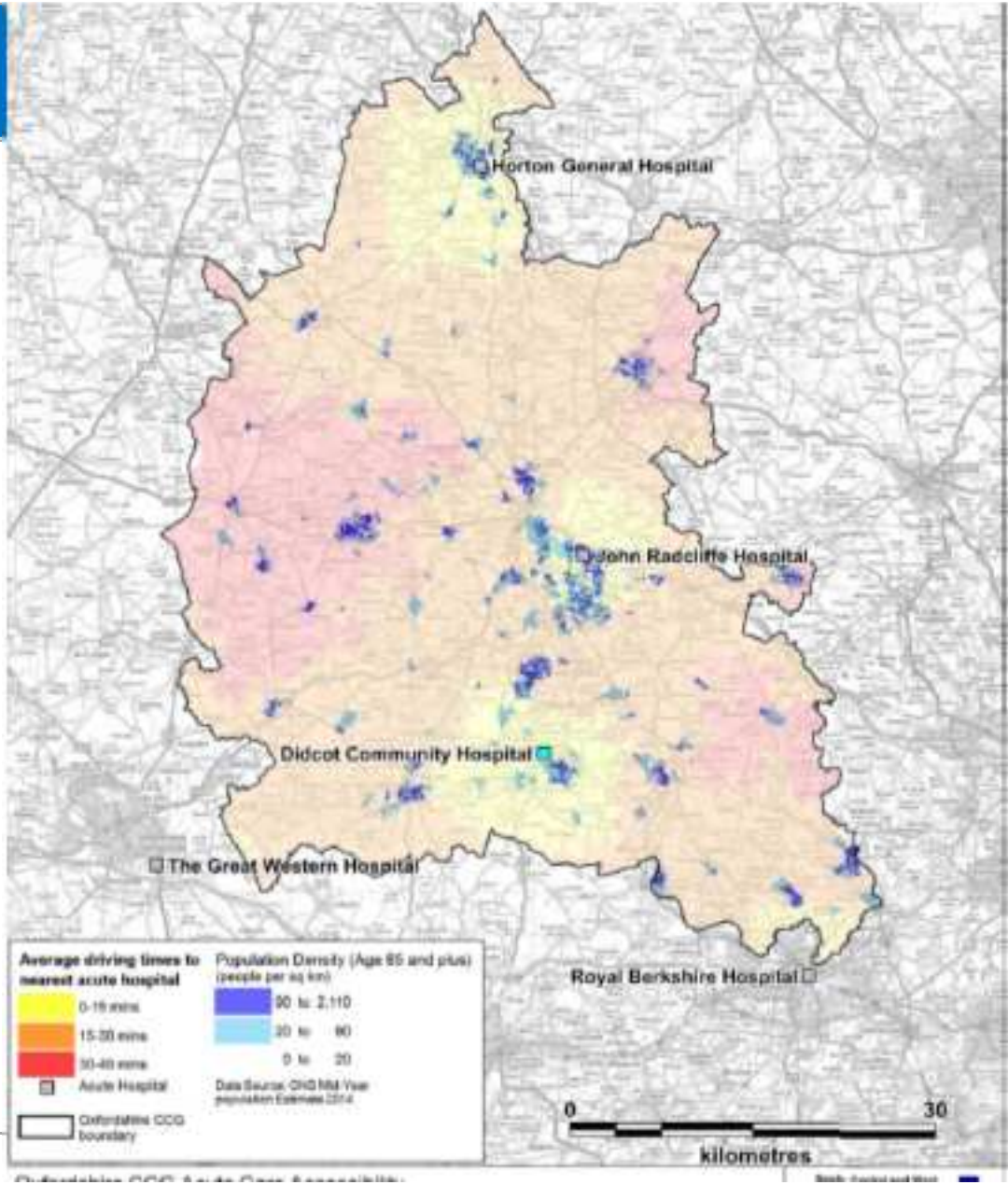
Travel times (South option – all ages)



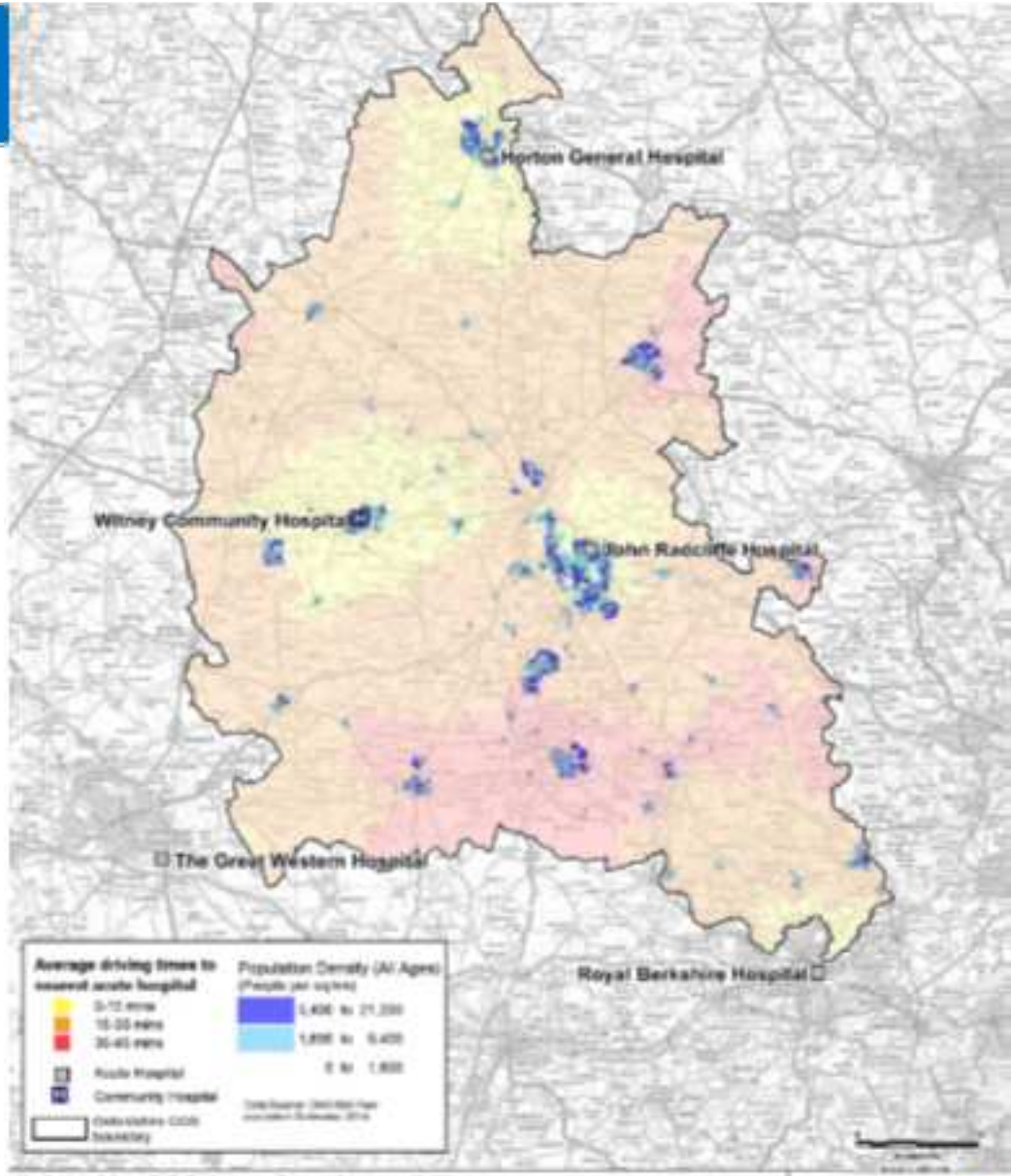
Travel times (South option 65≥older)



Travel times (South option 85≥older)

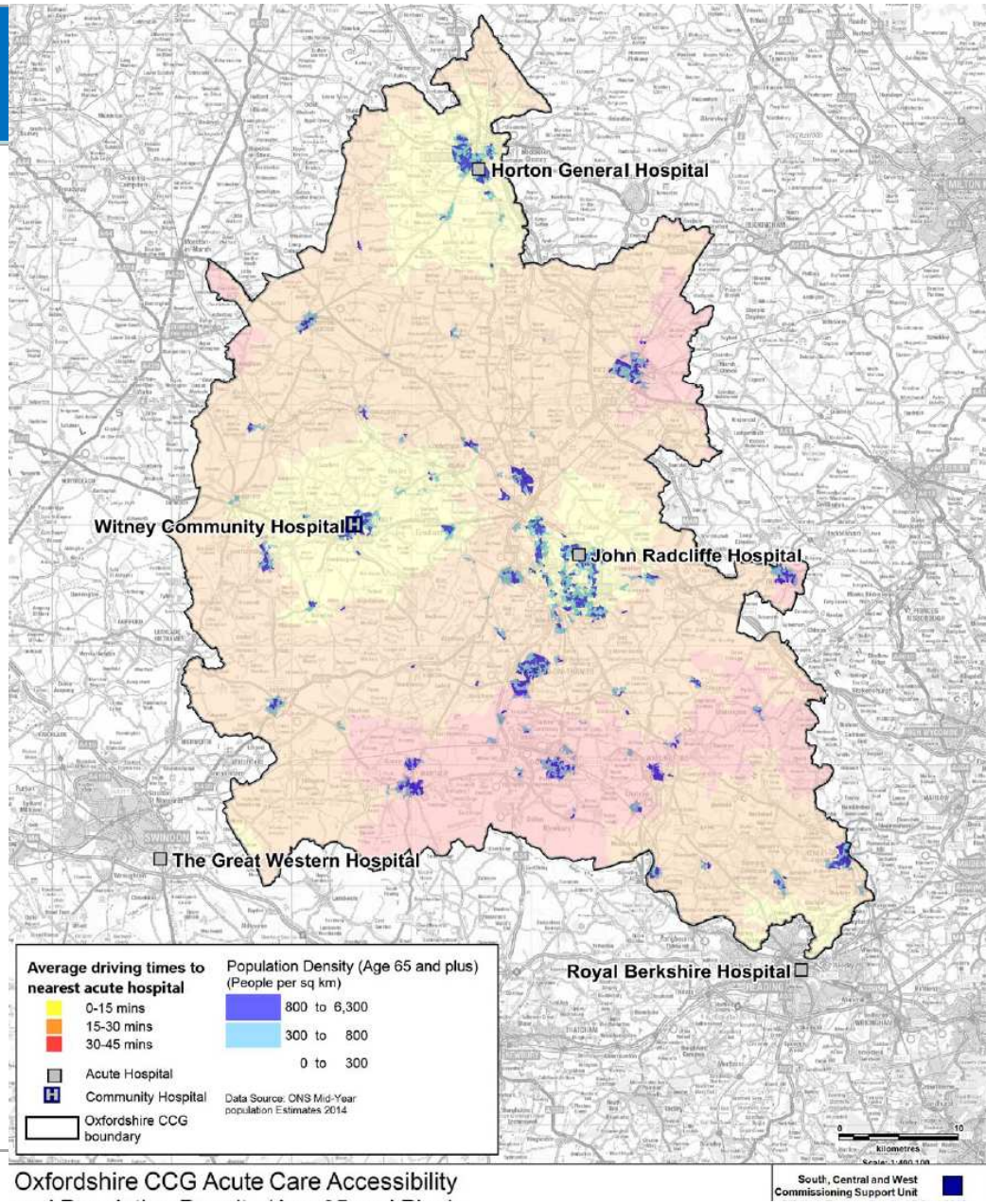


Travel times (West option - all ages)

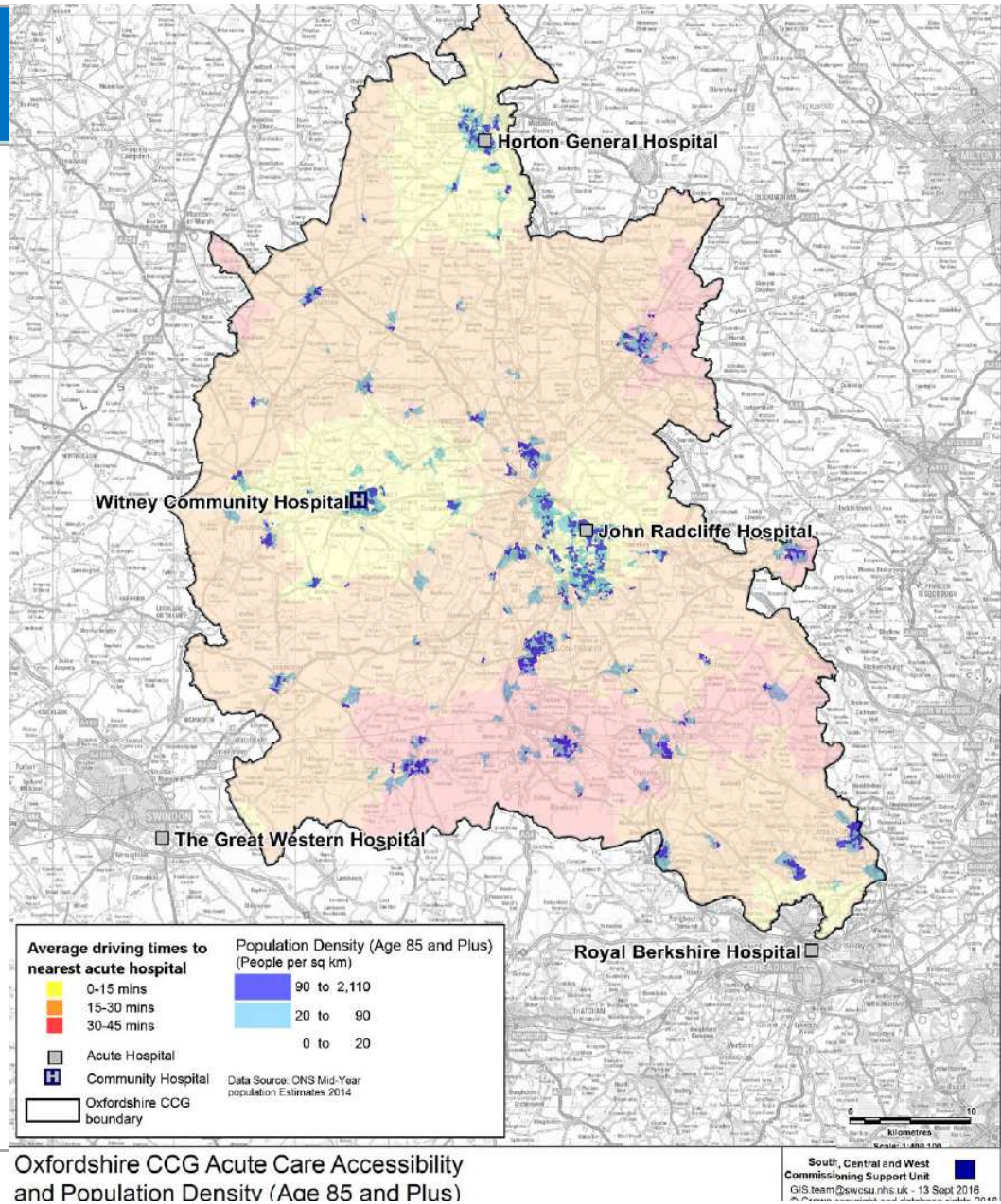


Oxfordshire CCG Acute Care Accessibility and Population Density (All Ages)

Travel times (West option - 65≥older)

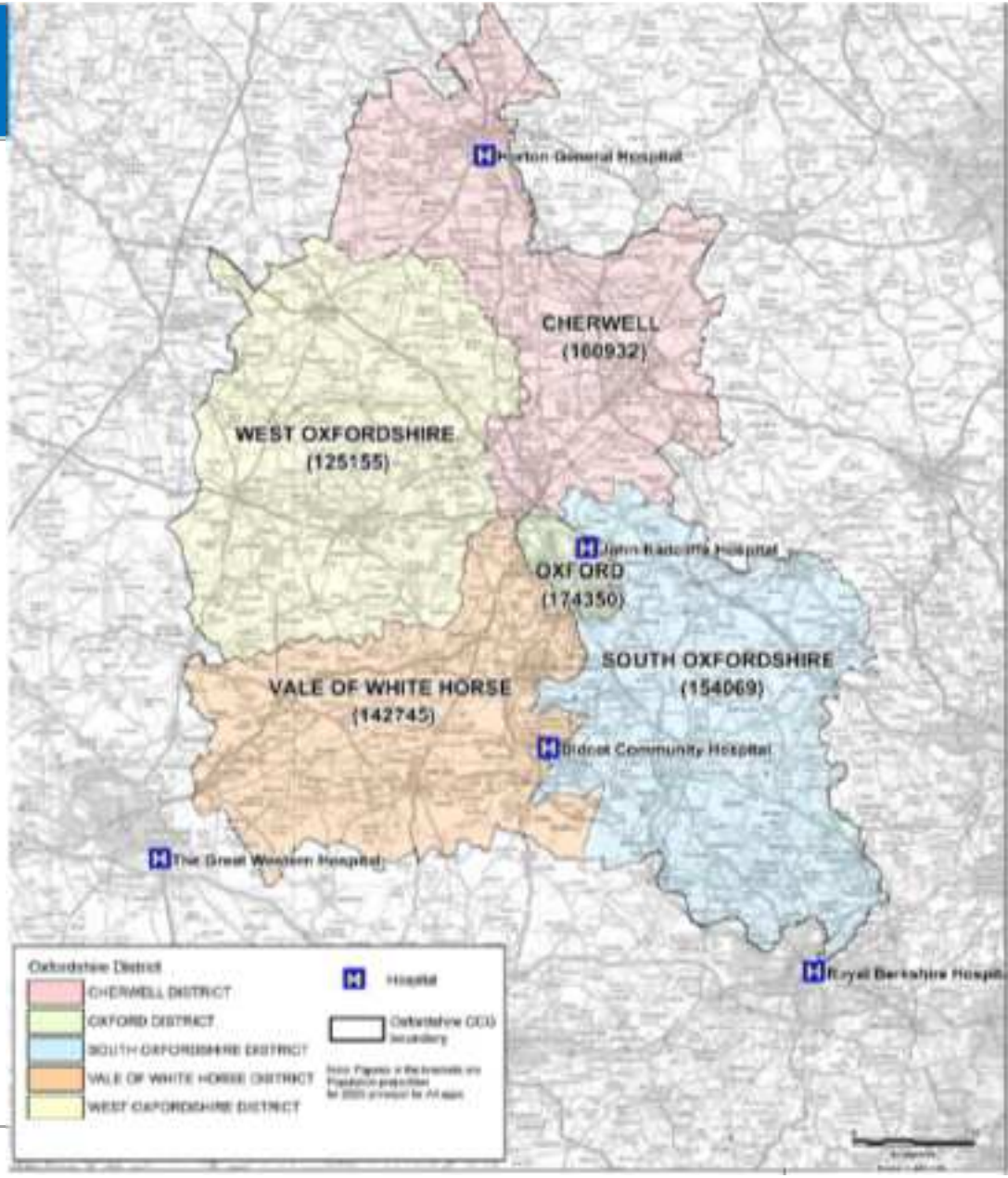


Travel times 85≥older (West option)



Predicted population growth (2025)

- Current populations as of 2016
  - Cherwell =146,822
  - West Oxfordshire = 111,198
  - Oxford=160,294
  - Vale of White Horse=127,289
  - South Oxfordshire= 140,329



Any questions?

Wrap up and next steps

Thank you